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Printed: 10/15/2013 NOV 18 2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION 1003) DATE GURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 506454 B WING 10/15/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTH VALLEY HOSPITAL 22 W 1ST STREET TONASKET, WA 98865 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE OROBS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) **INITIAL COMMENTS** K 000 This report is a result of an unannounced Federal Life Safety re-certification survey conducted at North Valley Hospital Extended Care, 22 W. 1st Street, Tonasket, WA on October 15, 2103 by staff from the Washington State Patrol, Fire Protection Bureau, Union Gap Detachment, This inspection was conducted in cooperation with the Survey Team from the Washington State Department of Social and Health Services (DSHS). The 2000 new and existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Regulrements for Long Term Care. The Long Term Care 58 bed facility, census of 54 was provided by the Resident Care Manager and 'verified by the Maintenance Director. The facility consisted of construction type V - 1 hour one story building. The building was built in 1984. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade have been provided with an all weather surface and lead to a public way. The facility is not in substantial compliance with the Life Safety Code 2000 Edition as adopted by C.M.S. All of the findings were in the existing portion of the building. The Surveyor was: Deputy State Fire Marshal Nursing Home Surveyor 28058 The Surveyor was from: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE For

following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Any deficiency statement edding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		505454		B. WING _		10/1	5/2013
NORTH VALLEY HOSPITAL 22 W 1			DRESS, CITY, STATE, ZIP CODE 1ST STREET SKET, WA 98855				
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
K 000	Washington State Fire Protection Bure 2715 Rudkin Road Union Gap, WA. 98 Telephone: (509) 57 FAX: (509) 57 28058	Patrol Bau 1795 75-2190 76-3002 DSFM		K 000			
K 012 SS=D	· · · · · · · · · · · · · · · · · · ·			K 012			
.	•						
	Based upon observe facility falled to main rating of the walls we smoke in the event this would allow smo	ot met as evidenced in ation and staff intervintain the fire construc- thich will resist the particle will resist the particle will resist the even of a fire. In the even oke to move between the patients, visitors, d fire.	lews, the extion assage of t of a fire, or the				
	The findings include	, but are not limited	to:				Variable 1
THE PROPERTY OF THE PROPERTY O	11:15am to 12:10pm	our on October 15, 20 in penetrations and b isserved in the following	reaches				The state of the s
TOP-ANGELING AMERICAN CONTRACTOR OF THE STATE OF THE STAT	At 11:85am, I obser cailing tiles of the fir Extended Care,						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTEL	A CAUMERINAUE	A MEDICAID SELA	IVED			- OMB MC	<u>). 0938-0391</u>	
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
505454		B. WING		10/1	10/15/2013			
NORTH VALLEY HOSPITAL 22 W 1			DRESS, CITY, STATE, ZIP CODE IST STREET SKET, WA 98855					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	CULD RF	COMPLETION DATE	
K 012		served and discusse	d with the	K 012	**************************************			
K 075 SS=E	Soiled linen or trasi exceed 32 gal (121 density of contained does not exceed .5 capacity of 32 gal (any 64 sq ft (5.9-sq or trash collection r greater than 32 gal	r collection receptace L) in capacity. The r capacity in a room of gal/sq ft (20.4 L/sq r 121 L) is not exceeded in a rea. Mobile solution area. Mobile solution (121 L) are located in ardous area when no 5	les do not average or space n). A ed within led linen acties n a room	K 075				
· · · · · · · · · · · · · · · · · · ·	The facility has falls trash collection rec gallon capacity. Th	ot met as evidenced ed to maintain soiled eptacles to a maximo is is providing a fuel lacing patients, visito	linen or um of 32 load for					
÷	During the facility s from the hours of 1 linen and trash rece	e, but are not limited urvey on October 15, 1:150am to 12:100preptacies that exceeding in the following in	, 2013 n soiled ed 32	Line State of the				
	alcoves were being gallon, and some c greater than 32 gall staff indicated that	userved that all the or used to store 21 gal lean linen carts that t lons in capacity. Inte the blue clean linen or	ion, 17 totaled to prview with carts are	AMERICAN PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		505454	B. WING			10/	15/2013
NAME OF PROVIDER OR SUPPLIER NORTH VALLEY HOSPITAL				2	STREET ADDRESS, CITY, STATE, ZIP CODE 22 W 1ST STREET FONASKET, WA 98855		10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 075	Continued From pa	age 3	Ko)75		<u> </u>	The state of the s
K 147 SS=E			K 1	147			
	The facility has fail of electrical hazards	is not met as evidenced by: led to maintain premises free s. This could provide for expose staff and patients to					
	The findings include	e, but are not limited to:					
	between the hours while accompanied	ourvey on October 15, 2013 of 11:15am and 12:10pm, I by the Maintenance Director I hazards were observed in the					
·	1. At 11:33am, I ob	oserved that patient room #105					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED			
		B. WING			10/15/2013				
NAME OF PROVIDER OR SUPPLIER NORTH VALLEY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 22 W 1ST STREET TONASKET, WA 98855						
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTING CROSS-REFERENCED TO THE APPLICATION OF					
K 147	had a power strip for 2. At 11:49am, I obtained an unapproved items. 3. At 11:59am, I obtained an unapproved	or the tv, radio, and vcr. eserved that patient room #211 adaptor for tv and other eserved that patient room #217 adaptor for electrical items. e observed and discussed with	K	147					

ID prefix tag	Deficiency	Plan of correction	Completion date
K 012	Fire penetrations	Penetrations sealed by maintenance staff	10-15-13
K 075	Soiled linen or trash receptacle capacity	Soiled linen and trash containers will be limited to the 32 gallon capacity allowed. All others will be relocated or removed to meet requirement.	11-19-13
K147	Power strips	Power strips will be removed and replaced with approved grounded outlets with overload reset. A quarterly PM to oversee compliance will be established.	11-19-13

Lindowy. Michel, CED Vot 24, 2013